Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Texas Health Southwest

Respondent Name
Texas Mutual Insurance

MFDR Tracking Number
M4-15-1485-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
January 20, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "HRA has been hired by Texas Health Southwest to audit their Workers Compensation claims. We have found in this audit they have not paid what we determine is the correct allowable per the APC allowable per the new fee schedule that started 3/01/2008… "

Amount in Dispute: $111.60

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor provided hospital outpatient services to the claimant on the dates above and then billed Texas Mutual for codes 73020 and 73030. Texas Mutual paid the 73030 code but declined to issue payment of 73020 based on the NCCI Edits. The Edits indicate code 73020 can be paid separately from 73030 with the use of the appropriate modifier. The modifier used by the requestor is not one recognized by the Edits. Thus, no payment is due. "

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
April 23, 2014 to May 2, 2014	73020	$111.60	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the fee guidelines for outpatient acute care hospital services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 435 – Per NCCI edits, the value of the procedure is included in the value of the comprehensive procedure
   - 193 – Original payment decision is being maintained

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed service as, 435 – "Per NCCI edits, the value of the procedure is included in the value of the comprehensive procedure." 28 Texas Administrative Code §134.403 (d) states in pertinent part (d) For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided..." Review of the disputed service finds;

    a. CPT code 73020 was submitted with 73030.

   Per Medicare National Correct Coding Initiatives, this combination of codes may not be paid together unless a modifier and supporting documentation details a separate and distinct procedure. Review of the claim finds neither a modifier or documentation was found. The carrier's denial is supported.

2. Requirements of Rule 134.403 (b) were not met. No additional payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March 19 , 2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.